Please send completed form to:
VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV DRIVE, RICHMOND VA 23220

CLAIM FOR BENEFITS

FILL OUT THIS FORM COMPLETELY. ***SEE SPECIAL INSTRUCTIONS ON REVERSE SIDE.***
MEDICAL REPORTS SHOULD BE FILED WITH THIS CLAIM OR AS SOON AS POSSIBLE.

VWC FILE NUMBER _____ *(The file number is usually printed at the top right corner of mail received from the VWC.)*

Employee Name		Phone Number	
Address		Soc. Sec. No.	- -
City/State/Zip			
Employer's Name		Phone Number	
Address			
City/State/Zip			

Have you ever received an award or any compensation payments for this accident or disease? Yes ☐ No ☐
Claimant's average gross weekly wage at the time of the accident or diagnosis of the disease was $
Claimant's Employer's workers' compensation insurance carrier is _____

1. Complete this section describing accident or occupational disease or both:
   Accident: Accident Date: _____
   Location of accident City or County: _____ State: _____
   How did the accident occur? _____
   Nature of the injury: _____
   Disease: Date doctor told claimant the disease was caused by work: _____
   Name of Doctor: _____
   Nature or name of the disease: _____
   Date of last time exposed to cause of disease at work: _____
   Date you last work for this employer: _____
2. What specific benefits are you seeking? Check all that apply.
   ☐ Compensation for total wage loss for the periods listed below:
   From: _____ To: _____
   From: _____ To: _____
   From: _____ To: _____
   ☐ Compensation for partial wage loss for the periods listed below:
   From: _____ To: _____
   From: _____ To: _____
   From: _____ To: _____
   ☐ Compensation for permanent disability
   ☐ Payment of lifetime medical costs for this injury and/or disease
   ☐ Payment of specific medical bills (attach to this form) related to this injury and/or disease
   ☐ Death benefits to dependents or funeral expenses
   ☐ Other – Specify: _____

SIGNATURE OF CLAIMANT: _____ Date: _____ Phone:

[Office use: Filed_____ Last paid_____ Docket for_____ on_____ by_____]

FILING INSTRUCTIONS

(Instructions Updated 09/01/07)

Claim for Benefits
VWC Form No. 5

Filing a Claim:

IF YOU HAVE ALREADY RECEIVED WORKERS' COMPENSATION BENEFITS FROM YOUR EMPLOYER OR INSURER AND HAVE NOT RECEIVED AN AWARD FROM THE VIRGINIA WORKERS' COMPENSATION COMMISSION, YOU SHOULD FILE THIS FORM WITH THE COMMISSION IN ORDER TO PROTECT YOUR CURRENT OR FUTURE RIGHTS TO BENEFITS UNDER THE ACT. COMPLETE AND FILE THIS FORM WITH THE COMMISSION AS SOON AS POSSIBLE.

Complete as many of the questions on the reverse side as you can. If you do not know the answer, write "unknown" in the blank. Write "Attention APP" on the mailing envelope to help us process your claim more quickly. Also, send a copy of the completed form to your employer.

Special Filing Instructions on Attachments:

1. If your *claim has been denied*, attach a copy of the denial letter.
2. If you are applying for *benefits for permanent disability*, attach the medical report(s) which states the permanency rating and that you have reached maximum medical improvement.
3. If you are claiming or applying for *wage loss benefits*, you must provide the specific dates.
4. If you are requesting *payment of **specific** medical bills*, attach copies of the itemized bills.
5. If you are applying for *death benefits to dependents*, attach:
    a. Copies of the birth certificates for each dependent for whom you are seeking benefits.
    b. A copy of the marriage license if you are seeking benefits as a spouse.
    c. A copy of the death certificate.
6. If you are applying for *reimbursement of funeral expenses*, attach a copy of the bill(s).

IMPORTANCE OF FILING MEDICAL RECORDS:

- Medical reports should be timely filed with the Commission to support your work-related accident, occupational illness or disease claim before the processing of your claim can be completed.
- If you are unable to obtain copies of your medical report(s) and bill(s), you may request a subpoena by sending the name and address of the medical provider to the Clerk of the Virginia Workers' Compensation Commission. A $12.00 cashier's check or money order (personal checks will not be accepted), should be included for each subpoena and made payable to the "Sheriff" of the City or County where the medical provider is located. If you are not sure of the jurisdiction, please contact the medical provider to confirm the City or County in which they are located. The Commission cannot issue subpoenas outside the State of Virginia.

For questions or assistance with completing this form, please contact the Claims Examination Department using the Commission's Toll-free number at (1-877) 664-2566 or visit our Website at **www.vwc.state.va.us** to file your claim electronically.